BoardRoom Press

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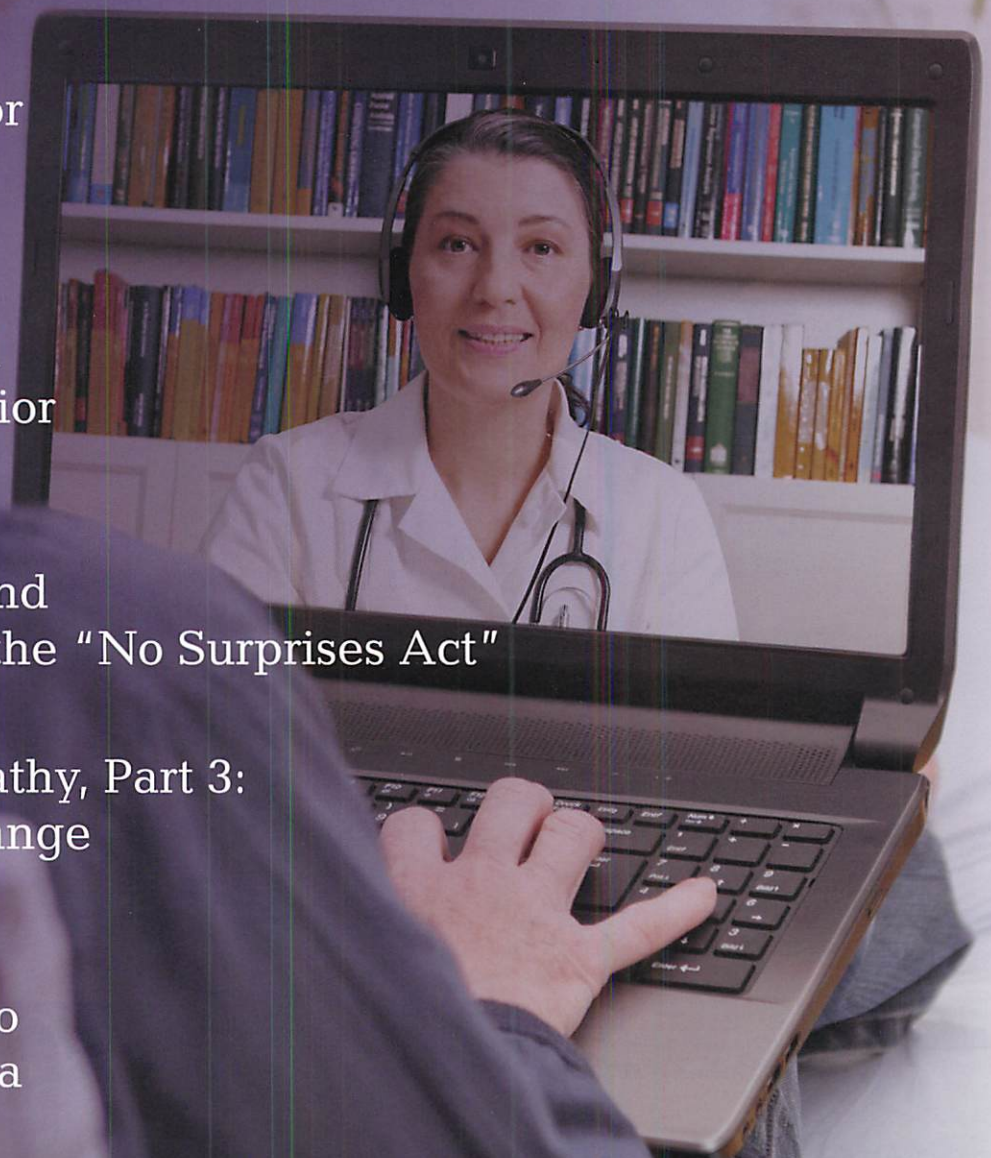

Resilience, Reinvention, Reemergence

A year ago, in this letter I expressed gratitude on behalf of The Governance Institute to the frontline care providers around the world who were putting themselves and their families at incredible risk to care for others. These providers are still doing this today, surge after surge. Each day the pandemic continues, our need for healing intensifies.

I wrote a year ago that I hoped the silver lining would be our greater collective ability to trust each other and build relationships in new ways and for new reasons. We are seeing growing evidence of this trust-building across the healthcare industry and in the public health and social services sectors. I sense a new energy, with more hopeful urgency, to take the lessons we learned last year and act on them in a meaningful way before the inertia sets in and we forget the magnitude of what has happened.

Our Education Agenda for this year focuses on three phases to help member organizations assess their position after a year of crisis and take concrete actions to accelerate forward movement towards healing and renewal, for the organization and its people, communities, and patients. Our aim is to enable our members to harness that energy to build stronger partnerships across multiple disciplines and agencies to become ever more resilient, to reinvent, and to reemerge at the end of this year with a bold vision of healthcare that will never be the same.

Kathryn C. Peisert,
Managing Editor

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Hybrid Event
September 18–19, 2021
InterContinental San Diego
San Diego, California

Please note: Conference expenses paid for by a board member can be claimed as a donation and listed as an itemized deduction on the board member's income tax return. Please consult your tax advisor for more information.

Virtual Care: Integration Disruptor or Final Piece in the Puzzle?

The following is an op-ed message for community health system boards.

By Daniel K. Zismer, Ph.D., Associated Eye Care Partners and University of Minnesota

COVID-19 released the genie from the bottle. For healthcare providers, that genie is "virtual healthcare." This article for community health system governing boards posits this central thesis: **virtual healthcare services must be considered as a necessary piece of the mosaic that is the strategic plan of integrated community health systems.**

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Before exploring this in more detail, a couple of definitions are in order. For purposes of this opinion piece, a community integrated health system includes a licensed hospital, a range of ambulatory health services, and affiliated physician clinics. It has various business and corporate relationships with physicians and other licensed providers, ranging from full employment to various other legal arrangements and affiliations with independent providers. The health system may be independent or affiliated with a larger regional or national health system. "Virtual care" is defined broadly here as access to a range of healthcare services, such as advice, education, and direct care services, facilitated by technologies that enable an exchange between a healthcare professional and a consumer by means other than an in-person encounter (e.g., telehealth).

What is the evidence for the central thesis? First, third-party payers report increases in provider claims for online, virtual doctor visits at levels at least tenfold of the volumes experienced in 2019, and most importantly, consumers like them! They can access providers conveniently and affordably. The message for community health system boards and senior leadership is to ignore virtual healthcare as a component of your organization's vision, mission, and strategy *at your peril.* There are large regional and national health systems with gold-plated brands that have virtual care on their drawing boards and in action, and there are upstart, well-funded, niche players coming for the most profitable pieces of the healthcare dollar with highly efficient and effective methods. Their aim is to establish new brand positions in the "mind space" of the markets that are the bread and butter of brick-and-mortar community health systems (and they are not interested in the business financed by Medicaid). Do they have designs on the destruction of community healthcare? Certainly not. They are not in the business of community healthcare. They are in the business of serving specific and targeted demands of identified consumers who seek a more efficient and cost-effective route to services. The aim is efficient access to strategically and financially productive markets. The mechanism of these strategies is virtual care.

Board members might ask, "Why would our patients use providers they don't know when we are all members of the same community, and we are here to serve them?" The answer is multi-faceted. Reasons range from the simple to the higher-order and more complex. On the simple end of the spectrum are obstacles like lack of appointment access, inconvenience of time and place, and limited availability of known and trusted providers. On the other end are the more complex such as, "I'm not sure which type of provider to see or even if the right one is available in my community." Price and price transparency are another factor. ("The doctor's office can't tell me what a visit will cost or what the hospital will charge me. I thought they all worked together.") Related is the cost-shifting by community health systems to cover their larger mission costs. A recent comparison of pricing for a screening carotid artery test showed a 400 percent difference in price between a community health system and a nationally known health screening company—one that advertises selectively and widely in target markets. Patients with high-deductible health plans take notice.

Key Board Takeaways

- Virtual healthcare services have moved to "main street." Health insurers and participating providers say, "there is no turning back—patients like it!"
- "First movers" are using virtual care to take market share cost effectively. Players include "big brand" national health systems and new "Wall Street" funded market entrants.
- Barriers to entry for many community health systems extend beyond the typical (money, know-how, and economics) to disagreements between the stakeholders over philosophy of need, quality of care, and who benefits and how. Consume too much precious time with these issues and market share moves away.
- Virtual healthcare as strategy for community health systems should rise to the top of governing board agendas as a topic of dialogue with senior leadership and affiliated providers. The central question is, "What is our role?"

What Does the Virtual Competitors' Playbook Look Like?

There are essentially three types of competitors to consider:

1. Larger integrated health systems that are already in the community
2. Larger integrated health systems that operate within the region (an extended car drive away)
3. Those that can "reach into markets" from virtually anywhere

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Strategic Teams in Healthcare: Some Perspective for Board Oversight

By Daniel Wolf, Dewar Sloan

As healthcare boards approach their work in strategy oversight, two questions emerge:

1. What is the right framework for strategy oversight, and what is the board's role in strategy formation, integration, and execution?
2. What is the board's responsibility for the capacity of their organization to deliver on the critical elements of strategy?

These questions are central to board engagement in the strategic agenda for growth, performance, and change.

Healthcare boards are duty-bound to address disciplined strategy oversight. Whether that responsibility is built on executive-driven practices or committee processes, most boards have some kind of framework that attends to strategy focus and choices. Effective board engagement in strategy is a value-added role, one with near-term and long-term consequences.

Strategy oversight is not isolated from other challenges in the organization. Assumptions made in the strategic agenda have connections with the design and structure of the organization. The appropriation of capital draws upon the best balance of priorities, timeframes, and resources. The many tasks of strategy execution connect people, culture, systems, and habits.

Strategic Challenges

Executives and board members know that the challenges of healthcare have never been greater. Healthcare is a capital- and talent-intensive world, with compliance issues, economic tensions, coordination issues, and complex incentives. Capacity concerns, process swamps, evolving risks, and disparity concerns are all part of the picture.

Executives serve in a world of healthcare innovation, shaped by technical options, digital platforms, social and economic concerns, and competitive forces. They navigate political and regulatory interests and contend with a host of moral and business concerns. The speed, risks, and costs of change inform the strategy work of management and governance.

Strategy shapes the balance of readiness and resolve. The readiness for near-term performance and long-term transformation is built on anticipation and practice. Taking care of today and getting ready for tomorrow is key. Forward plans and decisions are built on these foundations. The starting point for strategy oversight is anticipation.

Meeting these challenges depends on talented people at every level, serving across functions as the agents of making strategy happen. Some of this work gets done within well-established departments and functions, and some is accomplished by strategic teams of different kinds, connecting new processes and networks. Strategic teams are designed to adapt with a strong culture of collaboration. These teams are purpose-driven and are chartered to connect strategic direction, integration and execution, and readiness and resolve, and they are focused on results.

Organization Reset with Strategic Teams

Strategic teams exist formally and informally across a range of settings and roles. These teams:

- Bring people together with different talents and insights, by design—or sometimes by chance.
- Exist to coordinate efforts between processes and structures. Cutting across bureaucratic layers is a practical role for clinical and technical teams. Strategic teams operate as bridge builders for new programs and standards, procedures, and practices. They drive operational excellence, Lean and Agile efforts, and game-changing solutions across the enterprise.
- Serve as engines for adaptation, collaboration, accountability, and integration. These teams are essential to better, smarter, stronger, faster execution of almost everything in the work of healthcare organizations today. They are reshaping the structure and speed of change.

Key Board Takeaways

- Remember that the strategic agenda of an organization includes the whole of direction, integration, and execution. The most commonly cited problems in strategy are gaps between direction, integration, and execution.
- Ensure that the board oversees strategic direction along with the organization's capacity for making things happen.
- Consider how strategic teams of different kinds can serve as engines for enhanced strategy integration and execution.

Different Kinds of Strategic Teams in Action

There are a wide range of team designs and action, with at least 20 different kinds of strategic teams at work in hospitals and health systems.[1] Most are focused on challenges in three areas:

- **Compliance teams** are chartered to tackle the work of regulatory compliance, policy and procedure design or redesign, risk analysis and management, and information design and standards.
- **Integration teams** are chartered to deal with group interaction, process order and arrangement, service coordination, technology platforms, networks, resources, supply chains, quality models, cost/value efforts, access models, capacity management, and capital programs.
- **Discovery teams** are chartered to address opportunities, risk factors, problems, solutions, unmet needs, disruptions, change drivers, and different paths or "vectors" for healthcare innovation.

Individual roles on these strategic teams are often determined by the availability of people with specific talents. That approach may be convenient, but a more deliberate and developmental approach would be to match people to the specific intentions and charter of the team by asking:

- Who has the specific talent, background, and experience to contribute?
- Who has the presence, maturity, and character to contribute, engage, and perform?

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1 For more information on these strategic teams, see Dewar Sloan's *2020 Survey of Strategic Teams in Healthcare.*

Three Ways to Build a Strong Board–Senior Leader Partnership

By Rulon F. Stacey, Ph.D., FACHE, University of Colorado Denver and Guidehouse

The stronger the relationship between a hospital board and its senior leadership team, the better the clinical and financial performance of the organization.

This correlation has proven true at every hospital with which I have worked. But developing a dynamic relationship rooted in trust does not happen by accident. Such relationships are built by design—beginning with an effective process for engaging the senior leadership team.

This article highlights three areas where hospital boards have significant opportunity to create a strong sense of partnership with senior leaders that sets the stage for performance excellence.

Opportunity 1: CEO Selection

High-performing boards make only one personnel decision: the selection of the CEO. However, while this decision rests with the board, it is crucial for board members to remember that senior leaders are savvy and will see through any attempt to emphasize symbolism of a CEO choice over the substance of the individual selected. As a result, selection criteria should center first and foremost on the leadership acumen of the CEO. When boards prioritize broad depth in leadership and the ability to engage and guide an organization in selecting a CEO, they demonstrate high regard for the senior leadership team and earn the respect of senior executives.

Unfortunately, many hospital boards have gotten off-track in their selection of a CEO by focusing more on how their choice will be viewed by internal and community groups rather than on the CEO's leadership skill and experience. For instance, some boards believe that the way to show their communities that the hospital prioritizes quality of care and the patient experience is by hiring a physician to lead the organization. But while there are many examples of world-class leaders who are physicians, not *all* physician leaders are meant to be hospital CEOs. When boards emphasize medical training over the ability to provide a strong sense of direction and drive high levels of performance, they miss a critical chance to help shape the organization's future.

How did some boards end up putting symbolism over substance in their CEO selection process? This trend was summarized in a December 2016 *Harvard Business Review* article, "Why the Best Hospitals Are Managed by Doctors."[1] Using rankings from *U.S. News and World Report* to make their argument, the authors concluded that because of "the emphasis on patient-centered care and efficiency in the delivery of clinical outcomes...physicians are now being prepared for leadership." Independent of the fact that there is no correlation between an emphasis on patient-centered care and physicians being prepared for leadership, the *U.S. News and World Report* data is notably unscientific and not capable of being used to draw such conclusions.

However, the concept that led to the title of the article has expanded and grown—and it has now influenced the CEO selection process of many hospitals over the past several years. Some boards have even gone so far as to state that they are *only* looking for a physician to appoint to the role of CEO. In these boards' view, such a pronouncement assures the hospital's medical staff that the new CEO will have "walked the walk" and thus will have instant credibility with the medical team, as argued by the authors of the *Harvard Business Review* article.

The problem is that narrow guidelines for the CEO search often raise more questions than the board may have anticipated. These include the following:

- Are physicians more aligned with quality than others in the organization?
- Could the emphasis on physician leadership be perceived as a slight to nurses, the majority of whom are female? If a male physician is selected, could this decision also be viewed as a lack of interest in promoting women to leadership roles in healthcare?
- If board members are really concerned about quality of care, shouldn't the board also consider hiring a nurse to fill this C-suite role?
- Do physicians care more about quality of care than administrators? Are they more prepared to create processes that address quality of care on a large scale than other healthcare leaders?
- If the board establishes that it will hire a physician, is there a particular specialty that will be prioritized? During these discussions, would a pathologist, an internist, or a physical medicine and rehabilitation specialist be held in the same regard as a cardiologist or neurologist?

These are all fair questions. They quickly show that a predetermination by boards to select a particular type of candidate raises more questions among the community, hospital leaders, clinicians, and staff than it answers. Further, when board members fail to appoint a seasoned leader as CEO, the decision can strain

Key Board Takeaways

- **Base CEO selection on substance before symbolism.** Make it a priority to select a CEO who has the necessary skills and experience to lead the organization toward continual improvement; not just someone who will appease internal or community groups due to their role or status. In doing so, board members assure other senior leaders of their respect for the institution and for the expertise that other leaders bring to the table.
- **Have an effective annual board self-assessment process.** This should include an external evaluation with year-over-year performance comparisons and peer comparisons, as well as a senior executive review of the board. Conducting a thorough self-evaluation will indicate to senior executives and the rest of the hospital that everyone in the organization is engaged in improvement for the betterment of patients.
- **Establish and continually monitor action plans for boards and senior leaders.** An action plan reinforces to senior leaders the behaviors that are expected throughout the organization and builds trust between boards and senior leaders.

1 James K. Stroller, Amanda Goodall, and Agnes Baker, "Why the Best Hospitals Are Managed by Doctors," *Harvard Business Review*, December 27, 2016.

relations with other C-suite members. It can also demotivate the team—an action that will have ripple effects throughout the hospital.

Board members should adopt a rigorous process for identifying, screening, and selecting hospital CEOs. Key questions that should guide the board's efforts include the following:

- Is the CEO candidate a Fellow of the American College of Healthcare Executives? This distinction demonstrates the depth of the candidate's commitment to healthcare leadership, as recognized by leaders in the field.
- Does the individual have requisite experience in a similar organization? Such experience instantly engenders trust from other senior executives and stakeholders.
- If the candidate is a physician or a nurse, does the candidate also possess leadership training that would empower the candidate to lead teams with diverse skillsets, respond with resilience and agility as business conditions change, and motivate staff across the organization during a crisis?

The key is to select a CEO who can lead the entire organization toward continual improvement in all areas. In doing so, board members assure other senior leaders of their respect for the institution and for the expertise that other leaders bring to the table.

Opportunity 2: Conduct a Board Self-Evaluation

Annual self-evaluations of board performance go a long way toward promoting engagement with senior leaders and securing their respect and trust. These evaluations make it clear that just as board members are dedicated to providing feedback to hospital leaders, they are equally invested in assessing their own performance for the good of the organization. This process also lends credibility to all other hospital evaluation processes, beginning with the CEO evaluation.

To be effective, the board self-evaluation process should provide three meaningful data points across dozens of performance categories:

- How the board performed this year
- How this year's board performance compares with last year
- Where the board's performance stands in relation to its peers nationally

Further, an effective annual self-evaluation process by a high-functioning board will comprise both an external self-review and an internal review conducted by the hospital's senior leaders.

External Self-Evaluation

At least annually, boards should hire an outside firm to assist board members in conducting a thorough self-evaluation that includes year-over-year performance comparisons as well as peer comparisons. Following the evaluation, board members should discuss areas of strength and opportunities for improvement, developing a plan for enhanced performance in the year ahead.

For example, **Exhibit 1** shows a sample assessment overview created by The Governance Institute that can be used as part of the board self-evaluation process. The data featured in this example shows that this hypothetical board performed incrementally better in "Overall Board Effectiveness" in 2020 than it did in 2019. Additionally, we can see that the board performed incrementally better in "Overall Board Effectiveness" in 2020 than those in its peer group.

More important, this board self-evaluation gives board members a chance to review not only the overall effectiveness of the board, but also much more detailed observations about the board's fundamental fiduciary duties and core responsibilities. Each of these areas can be the recipient of further focus, detail, and review. Like this hypothetical self-evaluation, a good self-evaluation will produce for the board dozens of pages of data, back-up, industry comparisons, year-over-year trends, and much more. Any meaningful self-evaluation will be this detailed and will yield data the board can use for months to come.

Senior Executive Review of the Board

As mentioned earlier, the process of conducting a thorough self-evaluation will indicate to senior executives and the rest of the hospital that everyone in the organization is engaged in improvement for the betterment of patients. It also demonstrates that no one is above taking a hard look at their performance to benefit the communities the hospital serves. Through this effort, board members foster higher levels of engagement with senior leaders as well as staff—and patients reap the rewards.

Many senior leaders serve on not-for-profit boards themselves and bring deep understanding of the differences in responsibilities between board members and executives. Feedback from the hospital's senior leadership team not only presents a valuable opportunity to receive performance feedback from very capable leaders, but also offers another source of objective feedback regarding ways that the board can improve its performance.

For this reason, as part of a board self-evaluation process and as a way to further engage with the senior leaders, an effective board will develop and utilize an evaluation of the board by senior leaders. This evaluation should:

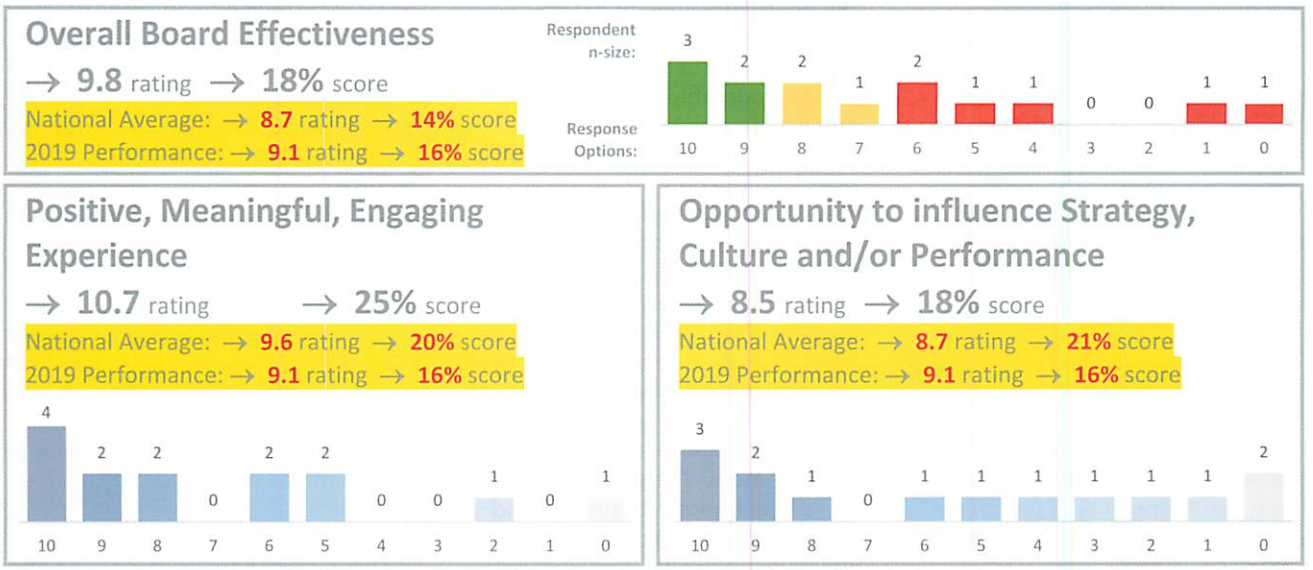
- Be identical from year to year to show trends.
- Allow confidentiality for each senior leader.
- Ask meaningful questions of senior leaders, such as:
  - » Does the board fully understand the difference between governance and management?
  - » Are all board members equally engaged in the process of governance?
  - » Does the board listen to advice and counsel from senior leaders?
  - » Is the board fully engaged in the process of strategy?
- Allow for written comments in support of the numerical answers.

After receiving the results of the self-evaluation and the senior leader evaluation, a board that is intent on creating a meaningful relationship with its leadership team will hold itself accountable just as the board holds senior leaders to account. This is done by creating an action plan each year as a regular part of an annual board retreat and discussion.

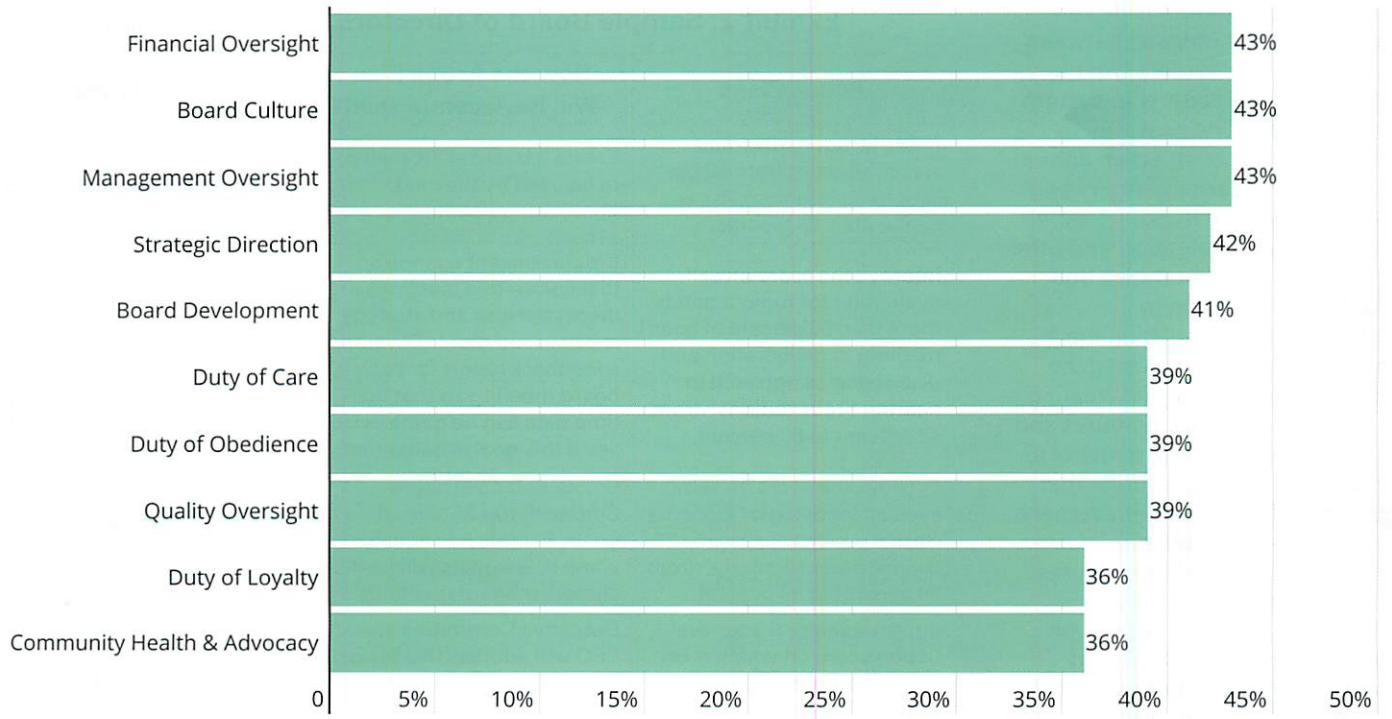
A meaningful action plan for improvement is essential. **Exhibit 2** shows an example of what an action plan might look like and how to establish a schedule for appropriate follow-up. Such an action plan reinforces to senior leaders the behaviors that are expected throughout the organization. It also builds trust between boards and senior

Exhibit 1: Sample Assessment Overview

→ 14 of 15 board members responded to your board's self-assessment, resulting in a 93% participation rate.
→ The Board gave an overall effectiveness rating of 9.8 out of 10, with 18% of the board selecting the highest possible rate.
→ This report utilizes top-box scoring, which is the percentage of respondents that selected "Very Effective".



Fundamental Fiduciary Duties and Core Responsibilities



Source: Board Compass®: The Governance Institute's Board Self-Assessment, 2021.

leaders by letting senior leaders know: "We're in this together."

This process is in addition to the formal review of the CEO that board members conduct at least annually. Board members also traditionally receive feedback from the CEO on the reviews that the CEO provides to the rest of the senior leadership team.[2] These processes offer meaningful opportunities to reinforce desired behaviors. They also present a vital opportunity to establish a concrete plan for improvement, where needed.

Opportunity 3: Look for Ways to Eliminate Variation in Processes

One of the key steps toward improvement of any process—or, by association, any organization—is the ability of that organization to identify best practices and to drive adoption of best practices throughout the entire entity. As the literature has shown, the best way to achieve this outcome is to identify and eliminate any variations in best practices as well as eliminate duplicate processes.

For a board to secure an optimal relationship with the hospital's senior executive team, the foundation of processes built on best practices must be formalized and replicated over and over. As variation is driven out, meaningful relationships between the board and senior leaders can be "hardwired" into the leadership system of the organization. The best way to ensure this is by establishing an annual process by which board members and senior leaders take the lessons learned from the board self-evaluation and other strategic planning opportunities and work together to apply them.

For example, after completing the board self-evaluation, undertaking the strategic planning process, and creating a balanced scorecard, board members and senior leaders should design a matrix to drive discussion around the topics that are central to performance improvement. (See the example in **Exhibit 3.**)

As reflected in Exhibit 3, to decrease variation in board discussion topics and reduce confusion around senior leadership assignments, the board should create an annual board agenda process template. This template enables the board—with input from senior leaders—to identify the most important topics to be discussed during the year, including topics that are mandated by law. It also sets topics for discussion well in advance. The benefits of a board discussion template include:

- **Clarity from the board as to what the board will look for in specific reports**: This process helps eliminate confusion among the senior leadership team and facilitates a process for communication between the senior leadership team and the board.
- **Clear priorities**: The template in Exhibit 3 gives the board and senior leadership team an at-a-glance view of the priorities of the organization. This reduces the potential for senior leaders to engage in projects that are not in keeping with the board's strategic vision.
- **A vision for clinical and financial improvement**: The primary objective of the board is to protect and enhance quality of patient care. However, absent healthy financial performance, the ability to provide patient care is compromised. This template gives the board, physicians, and senior leaders a visual representation of the work that is needed to secure the organization's clinical performance and financial health. It also provides a timeline for the board to address specific issues.

A Way to Promote Trust: Invite Senior Leaders to Evaluate the Board

Leading hospital boards invite senior executives to evaluate the board's performance. It's a process that facilitates higher levels of collaboration and engagement and promotes an atmosphere of respect and trust. To be effective, these written reviews should:

- Be replicated each year to show trends in feedback received.
- Include both numerical scores as well as areas for open feedback.
- Take great care to anonymize the feedback given by senior leaders.

A Matter of Trust

The extent to which the board effectively engages the organization's senior leadership team will greatly influence the hospital's clinical and financial

Exhibit 2: Sample Board of Directors 2021 Action Plan

Action Plans	How the Action Plan Will Be Accomplished	Action Assigned To
Improve board diversity selection score from 60 percent to no less than 75 percent within 12 months.	Create a board skills matrix to be used by the next nominating committee cycle.	Nominating Committee Chair
Improve the score on self-evaluation for topic "spends more than 50 percent of board meeting in deliberation and discussion as opposed to hearing presentations" from 40 percent to 60 percent.	Create consent agenda so that committee meetings are discussed less and strategy is discussed more. Develop a feedback report for each board meeting so that real-time data can be gathered to see if this goal is being met.	Board Chair and CEO
Improve the score on self-evaluation for topic "monitors clinical performance in top 20 clinical areas regularly" from 60 percent to 90 percent.	Create Balanced Score Card with top 20 clinical goals. Establish in advance when these goals will be discussed at board meetings.	Quality Committee Chair and CMO
Improve senior leader evaluation score on whether or not all board members are equally engaged from 50 percent to 70 percent.	Executive Committee and CEO will address this topic with response from senior leaders and discussion in executive session.	Board Chair and CEO

2 Note: Evaluation of senior leaders should occur no less than annually. However, under certain circumstances and in the event of a crisis, boards should consider speeding up the timeline for performance reviews—such as moving to monthly or quarterly check-ins—and setting goals for changes in behavior, where needed. For more information, see Rulon Stacey and Wayne F. Cascio, "Assessing Senior Leaders' Performance during COVID-19: 11 Questions for Boards," The Governance Institute, September 2020 (available at www.governanceinstitute.com/COVID-19-Resources).

Exhibit 3: Sample Board Agenda Process Template

Agenda Topic	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Report Presented	Creator	Presenter
Balanced Scorecard	X			X				X			X		Board of Directors	VP Quality	VP Quality
Code of Conduct	X												Board of Directors	Chief Compliance Officer (CCO)	CCO, Chair Compliance Committee
Community Benefit									X				Board of Directors	Assigned Senior Team Member	CEO/Assigned Senior Team Member
Compliance Report		X			X			X			X		Board of Directors	CCO	Chair, Compliance Committee
Compliance Training	X												Board of Directors	CCO	CCO
Confidentiality Agreements	X												Board of Directors	CCO	Governance Support Professional (GSP)
Conflict of Interest	X												Board of Directors/ Senior Executive Team	CCO	GSP
Employee Culture Survey								X					Board of Directors	CHRO	CHRO
Environment of Care Report			X		X			X			X		Board of Directors/ Board Quality Committee	VP Safety/Env of Care	CHRO/CNO
Financial Balanced Scorecard	X			X				X			X		Board Finance Committee	Controller	CFO
Philanthropy Report		X						X					Board of Directors	Foundation CEO	Foundation CEO
Grievance Report		X			X			X				X	Board of Directors	VPHR	CHRO
HR Report					X								Board of Directors (or Board HR Committee)	VPHR	CHRO
Joint Commission Scores			X										Board Quality Committee	CNO, CMO, CQO	CEO
Litigation Report		X						X					Board of Directors	General Counsel	General Counsel
Nursing Staffing/ Provider Staffing Effectiveness						X						X	Board Quality Committee	CNO, CMO	CNO, CMO
Employee Income/ Revenue Sharing				X									Board of Directors	CHRO/CFO	CHRO/CFO
Performance Excellence						X							Board of Directors	VPPE	VPPE
• Performance Improvement Report	X												Board of Directors	VPPE	Operational Executives
• PDCA Teams Update					X								Board of Directors	VPPE	VPPE
Physician Satisfaction Survey		X											Board of Directors	CHRO	CEO
Quality Committee Report	X			X				X			X		Board of Directors	CQO	CMO

performance. By focusing on these three opportunity areas for strengthening relationships with senior leaders and building trust, board members can create an environment that fosters excellence from the top down in 2021 and beyond.

The Governance Institute thanks Rulon Stacey, Director of Graduate Programs in Health Administration at the University of Colorado Denver, a Partner at Guidehouse, and a faculty member for The Governance Institute, for contributing this article. He can be reached at rulon.stacey@ucdenver.edu.

Providers, Payers, and What's Ahead with the "No Surprises Act"

By Stacy Hooper, Nathan Kottkamp, and Nate Lykins, Waller Lansden Dortch & Davis, LLP

Intended to address the persistent problem of balance billing patients for the costs of services of facilities and providers who are not in their health plan network—often with no prior notice—the "No Surprises Act" was signed into law in December 2020 as part of the Consolidated Appropriations Act, 2021.

The No Surprises Act's requirements become effective on January 1, 2022. With proposed regulations yet to be released, there could be a few surprises yet for healthcare providers. Below is an overview of the situation the new law seeks to address, the anticipated ramifications of the No Surprises Act (the Act) in practice, and issues to consider as the regulations are developed.

Overview

A "surprise" bill is an unexpected bill that a patient receives after he or she has obtained services from an out-of-network provider at an in-network facility. For example, a patient might have surgery at a hospital that participates in his or her health plan's network while the anesthesiologist and pathologist who provide services as part of the surgery do not. In this situation, patients are often surprised to learn that all of the services are not in-network, and they are stunned to discover that they are expected to pay the difference between the providers' fees and their health plan's out-of-network rates.

Surprise billing also creates problems for payers and providers. Payers are often required to spend additional time helping unhappy employees or enrollees understand why the services they received were not covered under their health plans. For providers, the disparities in payment rates may lead to uncollected fees and patient dissatisfaction. In response, multiple states have passed legislation aimed at addressing this practice. The Act is the first comprehensive effort at the federal level, and it affects health plans, hospitals, physicians, and air ambulance transportation companies.

The Act requires federal agencies including the Department of Health and Human Services and the Department of Labor to publish regulations and further requires some of these regulations to be published by July 1, 2021. Although the full scope of the regulatory scheme will not be known until final regulations are published, the Act itself makes it clear that healthcare providers, insurers, and self-insured health plan sponsors should be ready to address budgetary, operational, and administrative changes in the near future.

These changes include the following significant provisions.

Out-of-Network Services and Patient Financial Responsibility

- When a patient receives out-of-network emergency services, the hospital or physician providing emergency services may not hold the patient liable for copayments, coinsurance, and deductible amounts that exceed in-network rates.
- Emergency services must be provided without requiring prior authorization or any other term or condition of coverage and regardless of whether the provider is part of the patient's health plan network.
- Health plans must count any cost-sharing payments for emergency services toward in-network deductibles or out-of-pocket maximums.
- For non-emergency services, providers cannot impose cost-sharing requirements that would exceed the requirements applicable to in-network services, unless certain notice and consent rules are met.

Provider Reimbursement Rates

- Reimbursement rates will be set by applicable state law or, if no such law exists, a calculation that is based on the median contracted rate among other payers for the same service and in the same market.
- An "independent dispute resolution" mechanism will be established to arbitrate claims between providers and payers that cannot be resolved by the parties themselves. Using "baseball-style" arbitration, the dispute resolution entity must accept one of the parties' proposals without modification or "splitting" the difference.

Key Board Takeaways

- The No Surprises Act takes effect on January 1, 2022, and proposed regulations implementing some of the Act's requirements are expected on July 1, 2021.
- Healthcare providers, insurers, and self-insured health plan sponsors will need to quickly address the budgetary, operational, and administrative changes due to the Act.
- Hospitals or physicians providing emergency services may not hold a patient liable for copayments, coinsurance, and deductible amounts that exceed in-network rates.
- For non-emergency services, unless certain notice and consent rules are met, providers cannot impose cost-sharing requirements that would exceed those applicable to in-network services.
- It remains to be seen how the Act will affect the overall nature of network agreements and who will bear responsibility for the costly administrative burdens that will be needed to ensure compliance with the Act.

The end of surprise billing is certain to be a blessing for patients, but for providers, insurers, and employers, it could result in significant compliance hassles. Boards need to watch this law develop because the implementing regulations are yet to be proposed.

Other Patient Protections

- To facilitate patient understanding about pricing, health plans must provide "price comparison guidance" to their members by phone or online.
- Health plans must provide updated directories that include, among other things, network status of healthcare providers.
- The rules and scope of information in "explanation of benefits" documents will be expanded.
- Patients will enjoy a transition period of 90 days to facilitate continuity of care if a provider terminates network participation during a particular course of care.
- Transparency rules will require providers to inquire about a patient's health plan coverage at the time of scheduling and provide patients with a good faith estimate of anticipated charges. These transparency rules will be in addition to the Hospital Price Transparency final rule that became effective at the beginning of this year.

Unanswered Questions

Because the Act is a broad change to the laws applicable to an entire industry, it is not clear how its requirements will work in practice, and many issues remain to be clarified. Among them are issues such as:

- How will the Act affect the nature of network agreements overall? Will it compress prices such that the benefits of network agreements are significantly diminished or entirely meaningless?
- Who will shoulder the array of administrative burdens and costs that are necessary to ensure compliance with the Act?
- How will patient consents for waivers work in practice? Patients are already required to sign countless forms to receive medical treatment. Will there be protections to ensure that patients understand what they are signing when they sign forms related to out-of-network billing?
- How will the Act be applied in states where there are existing and complementary surprise billing laws?
- The Act provides that it does not supersede state law, except to the extent a particular state law prevents it from applying. It is not clear, however, how this will apply in practice.
- How, if at all, will Congress address surprise bills from out-of-network ground ambulance providers? Such providers are frequently a source of surprise bills, but the Act only addresses air ambulance providers (although it does establish an advisory committee to study ground ambulance bills).
- The Act attempts to remove patients from the process of resolving conflicts between health plans and providers regarding payment rates. Will it be effective in doing so, or will further legislative updates be necessary?

A more detailed discussion of the Act's requirements for health plans, providers, and air ambulance providers and the Act's dispute resolution procedure can be found at http://communications.wallerlaw.com/surprise-billing-white-paper.

The Board's Role

Regardless of how the regulations implement the Act, hospital and health system boards can take action now to be prepared for the new rules. First and foremost, providers should examine their existing experiences with balance billing. Doing so will provide important information about the context of the issue and how operational changes are going to affect business. Second, boards should consider how they will communicate with their constituents about the changes, which may include being prepared to answer to past practices, particularly those that may appear aggressive when compared to the new regime. Third, boards should consider whether the changes to the law should result in adjustments to negotiating strategies for network agreements going forward.

The board should be certain that the hospital's billing department is aware that the hospital will not be able to bill patients with health insurance for more than the in-network rate for emergency services. If a third-party service provider handles billing for the hospital, the contract(s) with that entity should be reviewed and, if necessary, amended. The contracts likely include a requirement that all billing be done in accordance with applicable law, but something more specific could prove helpful. At a minimum, review the contract's indemnity language to see if the hospital will be protected in the event the third-party service provider makes a mistake after the Act is effective. While third-party billing companies should be aware of the No Surprises Act, it could be helpful to confirm that they are aware of the Act and are taking appropriate steps to comply with it.

Because the dispute resolution process for payments will likely be expensive and time-consuming, the board should get a sense (or ensure that management has a sense) of the reimbursement rates that it will be willing to accept from insurers and what rates it will want to negotiate further. It might also be helpful to start discussing rates with common payers in the hospital's area. Subject to state law, the Act allows parties to agree on reimbursement, so the hospital may be able to avoid some difficult situations if it already has an idea of what a payer is willing to pay under the Act. Of course, to the extent that the hospital reaches a formal agreement about rates with a payer, the hospital may effectively be in-network with that payer, which means that the hospital may not have to worry about the surprise billing portions of the Act with respect to that payer.

Additionally, the board should review the consent process the hospital uses for non-emergency services. The board should ask management to ensure that the people responsible for obtaining patient consent are ready to obtain consent for out-of-network patients to be treated by a non-participating facility (i.e., the hospital). It is too soon to start working on the language of a consent form for this process, but once the Act's final regulations are published, the consent process will require close attention.

When the proposed rules that will implement the Act are published there will be a comment period. We recommend that boards review the regulations and utilize the comment process to make known any concerns or questions. It will be critical for board members to take the time to understand the rules and influence their development.

Conclusion

The Act is an attempt to address issues related to surprise billing, but the government must provide more guidance to enable affected parties to comply with the Act's requirements by January 1, 2022. For their part, providers, insurers, health plan sponsors, and others should continue to monitor activities related to the regulations and rollout of the Act. Among other things, interested parties will have an opportunity to submit comments to the proposed regulations following the publication of the Notice of Proposed Rule Making.

The Governance Institute thanks Stacy Hooper, Partner, Nathan Kottkamp, Partner, and Nate Lykins, Associate, Waller Lansden Dortch & Davis, LLP, for contributing this article. They can be reached at stacy.hooper@wallerlaw.com, nathan.kottkamp@wallerlaw.com, and nate.lykins@wallerlaw.com.

An Infusion of Empathy, Part 3: Take a Walk for Change

By David A. Shore, Ph.D., Harvard University

The following is the final article in a three-part series that looks in-depth at the power of empathy as a valuable asset to enable innovation and change in healthcare organizations.

The first two articles in this series examined empathy in the context of our current healthcare environment, as the coronavirus pandemic has retold us of our intensifying need to find better ways to address the human side of care. We recalled the important lesson from anthropologist Margaret Mead that the first sign of civilization was a mended femur bone, evidence that those around this human being took the time to help them recover. We considered compelling reasons why putting human needs first using empathy as a lens allows the business aspects to better fall into place. We have learned that empathy alone does not lead to action; most importantly, leaders need to implement exercises that both build empathy *and* facilitate change. This final article focuses on some key ways to build a culture of empathy, including the role of the board.

For many, when "empathy" is mentioned, the first image that comes to mind is walking in someone else's shoes. To cultivate empathy, you are invited to see life through someone else's perspective. However, even if one could do this, what would it look like? It's not enough to "talk the talk"—leaders must walk it as well. I have frequently observed that the best professionals are those who have one foot in the library and one foot in the street. This allows theory to inform practice, and practice to inform theory. The first step in an empathy walk is to know your purpose. If you don't know why you are there, then there is no point in being there.

Parents develop empathy for teachers once they themselves become teachers at home for their own children. Physicians develop greater empathy for patients after they have experienced a significant personal medical encounter. When they return to work, their patient satisfaction scores rise. Be mindful of the struggle of others, not just your own struggle.

Empathy, or the ability to place oneself in another's shoes, serves as a catalytic agent for becoming a high*er* performing individual or organization. As I have found in my related work on trust, there is a universality to the value of understanding the experience of others. Empathy allows you to communicate with care. Empathy walks are one external manifestation of this. Without empathy walks, individualistic leaders are limited by their own experience and incapable of envisioning possibilities outside their personal sphere.

We recognize that if you want to know what the customer buys, you need to look through the customer's eyes. The closer you are to something, the more it reveals itself to you. Yet, most managers know very little about how the age of COVID is impacting their team, both as people and colleagues.

The empathy revival process doesn't just happen. Initiatives involving children are noteworthy. Harvard's Making Caring Common Project has outlined five steps to strengthen empathy in a school's community. The first step is for educators to model empathy by attempting to see things from the student's point of view. In Denmark, there are compulsory empathy classes known as Klassens Tid. Every week for an hour, students are required to listen to each other, discuss their problems, and work together to find solutions. Perhaps as an aside (and perhaps not), Denmark consistently ranks as one of the happiest places in the world.

Key Board Takeaways

Bridging the Know-Do Gap

Empathy is a teachable skill; however, before it can be operationalized, it must be institutionalized. The tone is set at the top. If you don't have an empathic board, it is not modeling the behavior you want to see in your organization. Take on *ownership of empathy* as a core value of the board, and then enable the leadership team to put tools in its toolbox:

- Add empathy as a core organizational value and socialize empathy through communication and activities organization-wide. Consider mandating empathy training as part of the organization's workforce development training curriculum.
- Include empathy walks as part of the onboarding process for all new board members. Initiate annual empathy walks for existing board members, and in advance of commencing strategic planning.
- This is also the time for boards and leadership to address gaps in their core skills.

I have lost count of the board members and executives who have referred to empathy as a "warm-fuzzy concept" that isn't measurable and doesn't accomplish anything. Now, it is an imperative. It's time to reclaim empathy as a force for good.

My own journey was enriched two decades ago when I had the great honor to share the Harvard University podium for three days with a Tibetan Lama. He had just written a powerful book that guides us on how to respond with compassion and mercy to illness.[1] This three-day seminar was a game-changer for me. I learned far more than I taught and was introduced to the Tibetan belief system. Among the concepts that have continued to guide my own teaching and consulting is the understanding that even if we are saddened because we cannot cure everyone, we can find some joy if when we do attempt to help, our effort is 100 percent. I began to grasp an understanding that as much as compassion is a crucial part of caring that helps people heal, it can also help colleagues heal. It was at that time that

1 Chokyi Nyima Rinpoche and David R. Shlim, *Medicine and Compassion: A Tibetan Lama's Guidance for Caregivers*, Simon & Shuster, 2001.

I began formulating the PSEC model (pity, sympathy, empathy, compassion; depicted in the first article of this series) and came to understand that what we want in a healer is what we want in a manager: empathy and compassion.

The argument for stepping into another's shoes is that it is far more challenging to design solutions for problems you yourself have never experienced. Empathy walks and other strategies allow you to get "underneath the iceberg" and determine what motivates individual behavior. It is not until you actively listen and put yourself in others' shoes, that you give the individualized attention deserved.

It is far more challenging to design solutions for problems you yourself have never experienced.

The objective of empathy walks is to trigger greater understanding between people. Walking together to see places and layers through the lens of the guide's eyes enhances awareness. Choosing who leads the walks is crucial. Imagine how your leadership team might feel after a guided walking tour led by immigrants in which your team follow their daily paths. Walking other people's paths can trigger understanding of each other's experiences, and supports a positive coexistence. It is a catalyst for understanding diversity. Empathy walks often lead to compassionate actions. So, **let's walk together, in each other's shoes.** We all see life through the think lenses of our own experience.

Include empathy walks as part of the onboarding process for all new board members. Initiate annual empathy walks for existing board members, and in advance of commencing strategic planning. Consider mandating empathy training as part of the organization's workforce development training curriculum. Unlike some other KPIs, empathy is hard to measure, quantify, or test—but it can be done. This is an area where board expertise will be invaluable. Seattle's Virginia Mason Medical Center enjoys the reputation it has cultivated and all the benefits that accrue in good measure because of its Gemba walks on the Toyota Production line in Japan—a prerequisite for serving on the Virginia Mason board.

Making It Happen: The Role of the Board in Building a Culture of Empathy

Empathy building is a change initiative that is not currently in the woodwork of most healthcare organizations. The coronavirus pandemic has emphasized the critical need for trauma-informed managers and boards. The responsibility of the board is to establish a tone of empathy as a value and then hold leadership accountable to put the right toolbox in place.

Empathy is a foundational component of a high*er* performing organization, and as such, commands board engagement. Along with participating in empathy training, boards can play a central role in advancing the addition of empathy to the organization's core values, thus it becomes a North Star.

This is also the time for boards and leadership to address gaps in their core skills. Not surprisingly, when managers are asked what they value most in their team members, common responses include strong work ethic, dependable, self-motivated, organized, and productive. When we ask this same question of stakeholders, they consistently respond that they are looking for managers and organizations that "care about them." Upskilling for boards and leadership teams begins with minimizing attempts to anesthetize issues of the heart and rather proceed in mending femurs.

The failure to translate what is known to work into the care patients receive is dubbed the "know-do gap." This may be the biggest hurdle to successfully launching, leading, and realizing value from change initiatives. To bridge the know-do gap, boards need simple, scalable solutions.

We must help managers understand that empathy is not a weakness, and emphasize how much easier it is to design solutions to problems when you have stepped into others' shoes. Our current state only serves to reaffirm the importance of leaders and managers becoming more empathic and thus more resilient, not only with themselves, but also with others. Many leaders and managers have been emotionally hijacked by our current state and therefore fail to realize that they have a crucial role in empathizing and supporting their people and teams to transition safely and effectively.

Empathy is a teachable skill and should be taught. However, before it can be operationalized, it must be institutionalized. This is a compelling role for a governing body. Leaders must explore adding empathy and/or compassion to the organization's core values. Values such as respect, responsibility, integrity, resilience, and care are familiar core values in healthcare delivery organizations. These values are directly related to empathy, as they encourage one to place the needs of others before oneself. Adding empathy is a natural extension of the family-/patient-centered core value present in many healthcare delivery organizations. Organizations may also use their most cherished value to position themselves. For example, a hospice in Decatur, Georgia is named Symponia House. "Symponia" is the Greek word for compassion and can be translated as "to share the pain and act." Symponia House's slogan is, "We are compassion."

Over the next three years, we will see leading organizations make hyper-personalization in customer care a top goal. This begins with knowing your customers. Truly knowing your customers begins with empathy. Empathy and compassion soften resistance, build trust, foster engagement, improve outcomes, and catalyze innovation and change. It is hard to think of a more central goal for governing boards and senior leadership teams. In driving the future, boards do not want transformational change—they want transformational advantage. This requires socializing empathy on an enterprise-wide basis.

The Governance Institute thanks David A. Shore, Ph.D., for contributing this article. Dr. Shore is a former associate dean of Harvard University where he continues to teach and lead professional development programs. He is also the former distinguished professor of innovation and change at Tianjin University of Finance and Economics (China). He serves on various boards including McKinsey & Company. He is senior consultant on innovation at the United Nations. He can be reached at dshore@fas.harvard.edu.

Virtual Care...

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The local, larger integrated health system already has the advantage of brand recognition. It likely has already integrated a significant proportion of providers, across clinical specialties, as employees. Consequently, it can financially support a range of licensed providers coming off the in-person patient encounter frontlines to be stationed in the virtual care environment. It has the balance sheet to load the technology infrastructure on the front end in order to be first "market movers." The focus will be on select primary and secondary care concerns and conditions that lend well to an introductory virtual visit. With a number of these visits, real health value is realized by the patient, the trust is established, and patient loyalty begins to shift. The "telehealth" practitioner may hand off the patient to a services navigator to facilitate follow-up, in-person visits with a referral provider.

The familiar regional competitor may have the advantage of brand recognition as well. Their virtual strategy is to "reach in," typically with specialty-focused virtual care consultations; often clinical specialties that lend well to patient self-referral, such as non-acute orthopedic issues, pain management, select women's services, and chronic condition management. The virtual visits may even be provided at a nominal cost, and/or be fully covered by health insurance, with no out-of-pocket payment due from the patient. The end-game here is low-cost acquisition of strategically useful patients. These strategies can be quite successful, especially when the local community health system either doesn't offer a comparably appointed set of specialty services or can't provide comparable ease of access.

The third-class competitors are established "mega-brand" players like Mayo, the Cleveland Clinic, major academic health centers, and specialized centers of care such as MD Anderson, as well as new players to the local, regional, and national markets—highly specialized providers that can cost-effectively reach into any target market. Examples here include online pharmacy providers, online behavioral health providers, wellness and lifestyle medicine services providers, and the like. The national mega-brands have multi-media access opportunities to select markets, especially through social media "geofencing" strategies. Cleveland Clinic, for example, offers a number of smartphone apps to offer ease of access to a panoply of specialized clinical services and programs.

What Is the Greatest Risk to Community-Based Integrated Health Systems?

The greatest risk is not having the right conversation between governance and senior leadership. The right conversation is facilitated by the questions below. At the conclusion of the conversation a decision is made: "virtual care—we are in or out." The framework for the conversation includes, at least, the following questions:

1. What is our collective philosophy regarding virtual care—the community health system and all affiliated providers, whether they be independent or those employed by the health system? More specifically, do we have enough providers who are "believers" in virtual care?
2. Do we have the technology infrastructure sufficient to deliver on a virtual strategy, and if not, what will it cost?
3. Will the economics of a strategy be affordable to those who need to participate—especially independent practices? (Independent medical practices differ from each other on many factors that may deter them from being able to participate in virtual health strategies unless financial subsidies are provided.)
4. Will the politics of the collective medical staff facilitate the required, ongoing conversations, clinical model decision making, and action on a plan? Stated plainly, will the required provider groups collaborate and cooperate to make a strategy work?

So, is it a mistake for community health systems to leave the world of virtual care to others? Not necessarily, but if the answer is, "it's not for us," understand that the potential to create a fully developed integrated health system may be lacking and the lesser strategy may require the organization to harden itself against the strategies of competitors that have adopted and adapted an effective way to provide target patient markets with alternative pathways to the healthcare they seek to consume.

The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Chair and CEO, Associated Eye Care Partners, and Professor Emeritus, Endowed Scholar, and Chair, School of Public Health, University of Minnesota, for contributing this article. *He can be reached at dzismer@aecpmso.com.*

Strategic Teams in Healthcare...

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- Who has the social, political, cultural, and market perspective to contribute?

The broader formula for getting the right people on the right teams in the right roles with the right goals is management and leadership work, but *the board assumes oversight of the organization's capacity for making strategy happen.* That distinction is important as it provides a framework for executive and board dialogue on strategy.

Strategic Teams as Development Labs

Individuals bring different interests, knowledge, and experience to their roles on strategic teams. Clinical people learn to collaborate better when they work closely together on strategic teams. Technical people learn to adapt and enhance processes when they work with people in different areas, with different backgrounds. Managers learn to improve practices, solve problems, and reduce hassles when they serve together on strategic teams, building hard skills and soft skills along the way. More team exposure means more avenues for personal and professional development. Strategic teams also hold a great deal of promise for advancing the diversity, inclusion, engagement, and mobility goals of hospitals and health systems.

The Advantage of Strategic Teams

Healthcare leaders face many challenges with strategy integration and execution. A future-ready organization is essential. Strategic teams can:

- Complement the more traditional structures, departments, and functions of hospitals and health systems
- Contribute bench strength
- Connect strategy, talent, and culture
- Spark and accelerate change
- Tackle and resolve conflicts, problems, unmet needs, and tensions
- Advance the connections of technical, operational, and clinical work across the enterprise
- Spark innovation

Boards provide oversight for the strategic agenda of the institutions they serve. That includes working with the executive team to bring focus and order to near-term and long-term direction. In addition, boards provide oversight for the capacity to bring that strategic agenda together in a challenging value-driven era. Building capacity in the minds and hearts of the people who serve on strategic teams is management's charge. This takes us back to the beginning...does the board have a practical framework for strategy oversight, and is the organization equipped to engage the strategic agenda with talented people working on great teams?

The Governance Institute thanks Daniel Wolf, who leads the strategy leadership and governance practice of Dewar Sloan, for contributing this article. He can be reached at (231) 929-4545 or dwolf@dewarsloan.com.

Strategy in Year Two...

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Rebalancing asset allocation across the service delivery system can help reduce operating risk as external risks remain high. This might include converting short-term financing to permanent financing, and scrubbing operating models for accumulated assets that have increased operating risk but are not positively contributing to operating performance.

Conclusion: Strategic Financial Planning for an Uncertain Future Outlook

The impact of COVID on organizations, coupled with their relative pre-pandemic performance, will have an outsized influence on strategic financial planning for years to come.

Organizations with weak capitalization pre-COVID are likely to face significant short- and long-term viability concerns, and their boards may need to consider partnering with other organizations in the near future.

Moderately affected organizations with median liquidity, leverage, and profitability prior to the pandemic will likely face more short-term COVID-related pressures, and have an opportunity to reinvigorate their operating models moving forward.

Finally, organizations with limited COVID-related balance sheet and operating damage have a significant, once-in-a-generation opportunity to allocate capital and leadership toward their long-term strategic goals.

At the outset of the pandemic, hospital and health system boards were forced to confront myriad financial and operational pressures at once. As uncertainty continues in the second year of the COVID-19 pandemic, organizations that can balance these ongoing responsibilities while making more long-term strategic pivots will be best positioned for a still-uncertain future.

The Governance Institute thanks Mark Grube, Managing Director and National Strategy Leader, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. He can be reached at mgrube@kaufmanhall.com.

Strategy in Year Two of the COVID-19 Era

By Mark Grube, Kaufman, Hall & Associates, LLC

As the COVID-19 era enters its second year, the hospitals and health systems that have served on the pandemic's front lines continue to confront high levels of operational and financial uncertainty. As of this writing in mid-March, the overall number of COVID-related hospitalizations has steadily declined from a mid-January peak. However, epidemiologists continue to worry about the presence of several fast-spreading and potentially deadlier variations. And while the pace of U.S. vaccinations has picked up—to an average of approximately 2 million shots a day—the timeline for vaccinating a large proportion of the U.S. population remains murky at best.

Hospitals and health systems are also getting used to a new administration and Congress in Washington. While responding to the COVID-19 pandemic is the immediate healthcare concern of the administration, other issues likely will gain attention during President Biden's first year in office. These include the potential for:

- **Expanded coverage under the Affordable Care Act (ACA)**, including the introduction of a "public option" to compete against commercial health plans in the individual health insurance marketplaces. The administration has already announced a special enrollment period for the marketplaces to boost coverage in the wake of the pandemic's economic toll.
- **Reduced disparities in health outcomes**, beginning with a task force that will seek to reduce disparities in response, care, and treatment of COVID-19.
- **Heightened scrutiny of healthcare mergers and acquisitions**, which will continue the more aggressive position that federal antitrust enforcement agencies have taken in recent years.

Amid lingering COVID-related uncertainty and potential regulatory changes, hospital and health system boards must take the necessary short-term actions to live to fight another day, while mustering the energy to recalibrate their long-term trajectory and prepare for an increasingly value-based payment model. Boards with the ability to multitask those competing priorities will have the broadest options for blazing a sustainable path forward.

Live to Fight Another Day

The cost structure of hospitals is necessarily dependent on the slope of its revenue recovery curve, an increasingly moving target. To this end, organizations must begin to determine how the total cost of the care they provide measures up with the competition.

Ultimately, major changes in operations may be required to adjust to a long-term revenue loss whose exact level still remains unclear. What will the resulting healthcare delivery system need to look like? At this point, many boards and executives still have only a hazy idea of what their organization's new cost structure will need to be.

Rethink the Future in a Post-COVID World

Beyond the immediate financial and operational challenges of the pandemic, boards must also decide how to best steer their organizations toward a successful long-term operating model.

For hospitals and health systems, future success will be dependent on how well they can respond to customer needs at "purchasing events," when employees select health plans from their employers or consumers with non-acute issues decide where to access care. At the same time, the technology sector's economic dominance has significantly accelerated since the start of the pandemic. Verticals with a face-to-face orientation (e.g., retail, hospitality, and live entertainment) have been devastated by COVID-19. Within healthcare, access on demand is a new requirement for success.

More than ever, scale is critical to achieve these goals. We are seeing signs that health systems are moving beyond their traditional geographies in new merger activity, as the pandemic has accelerated the need to transform care delivery models and reimagine health system configuration. Systems also are restructuring their portfolios to monetize or exit underperforming assets and strengthen their financial viability.

Aggressively Pursue "No Regrets" Strategies

The financial challenges brought on by COVID-19 will likely only increase the need for vertical alignment and readiness for value-based care.

At the same time, health plans and providers will have a greater incentive to integrate and maximize performance in value-based arrangements, a growing proportion of total revenue. This may involve expanding existing relationships or developing new partnerships to increase the number of covered lives across the most profitable lines of business, such as commercial and Medicare Advantage plans.

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Key Board Takeaways

- **Organizations with strength are in the best position to lead.** A strong balance sheet, scale, and revenue diversification can help weather uncertainty.
- **Math has never been more important.** Highly sophisticated monitoring, predictive modeling, and analysis are more necessary than ever to understand current position and future scenarios.
- **Multi-tasking organizations will have the broadest options.** The ability to simultaneously take on COVID as a chronic condition, recover financial stability, and reimagine strategic position is of critical importance moving forward.